aleracare
advanced specialty pharmacy

Hematopoietic
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height:	Weight:	Allergies:	Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No

Does the patient need interpreter services: ◯ Yes ◯ No

Documentation (Required)

◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Specific Labs Needed (note: send ALL labs, must include specific labs listed here)

◯ Hep B Test ◯ HIV ◯ HIV co-infection ◯ Other: _____

Medication	Sig	Qty	Refills
◯ **BARACLUDE®**	◯ 0.5 mg tab po daily (Naïve pt or adolescents ≥ 16 yo) ◯ 1 mg tab po daily (Lamivudine -Refractory pt) ◯ 0.05 mg/ml ◯ Dose adjustment by Creatinine Clearance (if less than 50 ml/min):	30 or 90 30 or 90 210ml 210ml	
◯ **EPIPEN®**	◯ 0.3 mg IMx1, may repeat ◯ Epipen Jr (for Peds less than 30 kg) ◯ 0.15 mg IMx1, may repeat		
◯ **EPIVIR® HBV** 100mg	◯ 100 mg po daily	30	
◯ **EPIVIR®** 150mg	◯ 150 mg po BID (only for co-infected pt with HIV)	60	
◯ **HBIG**	(Hepatitis B Immune Globulin- single use vial) greater than 1560 International Units/5 ml (greater than 312 International Units/ml) ◯ 5 ml IM in 2 divided doses, every ◯ 2 ml IM in 2 divided doses, every ◯ 10,000 International Units(32 ml) in 250 ml NS, IV over _____hour(s), every _____for _____infusions ◯ Infusion at Physician's office or Home infusion ◯ Alt. Dosage: _____	5 ml vial 2 of 1 ml vial ___of 5 ml vials	
◯ **HEPSERA®** 10mg	◯ 100 mg po daily ◯ Dose adjustment by Creatinine Clearance (if less than 50 ml/min):	30	
◯ **PEGASYS®** 180mcg	◯ PFS (pre-filled syringes) Vial "Will dispense PFS (prefilled syringe) unless VIAL is marked" ◯ 180 mcg SQ QWK Alternative dosage	28 days	
◯ **TYZEKA®** 600mg	◯ 600 mg po daily ◯ Dose adjustment by Creatinine Clearance (if less than 50 ml/min): 30	30 30	
◯ **VIREAD®** 300mg	◯ 300 mg po daily ◯ Dose adjustment by Creatinine Clearance (if less than 50 ml/min):	30	
◯ **OTHER:**			

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature _____ Date _____